Alabama Medicaid

Health Insurance Portability and Accountability Act (HIPAA)

Proprietary 837 Claim Batch Response
Vendor Specifications
Receipt from Alabama Medicaid

Original Publication: May 2003

Note: *The information in this document is subject to change. The use of this document is solely for the purpose of clarification. Please refer to the version number and effective date located in the footer of this document for the latest information available. Changes within the document will be in red type. A copy of the most current version of this companion document can be obtained from the internet at http://www.medicaid.state.al.us/HIPAA/index.htm.*

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1. Overview

The purpose of the proprietary claim batch response file is to communicate the results of pre-adjudication editing, to notify the sender of the acceptance or rejection of a claim prior to adjudication. The proprietary batch response will return error codes and error messages, which will provide detailed information about why the claim was rejected.

There will be one standard proprietary claim batch response format for the 837 D (Dental), 837 P (Professional), and 837 I (Institutional) transactions.

There will be up to 50 error codes returned in a response, with a 40-byte text description for each error code.

1.2 Audience

This document is written for the benefit of vendors who create software for providers that submit claims to the Alabama Medicaid Agency via electronic media.

2. Proprietary Batch Layouts

The layouts contain specific requirements to be used when processing data from the Alabama Medicaid Management Information System (AMMIS).

2.1 Accepted Claim Batch Response

Field Name	Field Value	Format (length)	Start Position	Stop Position
Delivery and Support System Return Code	00 or 20-29 or 50-55	Numeric (2)	001	002
Transaction Code	Code indicating the type of transaction and the path of entry into the system *See Appendix B for list of codes*	Alpha/Numeric (4)	003	006
Software Version	'00'	Numeric (2)	007	008
Trading Partner Id	Submitter Id from the 837 claim	Alpha/Numeric (9)	009	017
Record Type	'1'	Alpha/Numeric (1)	018	018
Translator Control Number	Control number assigned by the translator to each 837 claim submitted	Alpha/Numeric (15)	019	033
Translator Control Sequence Number	Uniquely identifies a claim/transaction.	Alpha/Numeric (4)	034	037
X12 Version	'4010'	Alpha/Numeric (4)	038	041
Batch Id	Batch filename	Alpha/Numeric (8)	042	049
Filler	Blank	Alpha/Numeric (4)	050	053
Provider Id	Provider Id submitted on the 837 claim	Alpha/Numeric (9)	054	062

Field Name	Field Value	Format (length)	Start Position	Stop Position
Recipient Id	Recipient Id submitted on the 837 claim	Numeric (12)	063	074
Check Digit	Recipient's check digit submitted on the 837 claim	Numeric (1)	075	075
Patient Control Number	Patient Control Number submitted on the 837 claim	Alpha/Numeric (20)	076	095
Billed Amount Sign	"+", "-", or " "	Alpha/Numeric (1)	096	096
Billed Amount	Billed amount submitted on the 837 claim	Alpha/Numeric (12)	097	108
From Date of Service	From DOS submitted on the 837 claim	Numeric (8)	109	116
Return Code	'A' for accepted.	Alpha (1)	117	117
Internal Control Number	ICN assigned to the 837 claim	Numeric (13)	118	130

2.2 Rejected Claim Batch Response

Field Name	Field Value	Format (length)	Start Position	Stop Position
Delivery and Support System Return Code	00 or 20-29 or 50-55	Numeric (2)	001	002
Transaction Code	Code indicating the type of transaction and the path of entry into the system *See Appendix B for list of codes*	Alpha/Numeric (4)	003	006

Field Name	Field Value	Format (length)	Start Position	Stop Position
Software Version	'00'	Numeric (2)	007	008
Trading Partner Id	Submitter Id from the 837 claim	Alpha/Numeric (9)	009	017
Record Type	'1'	Alpha/Numeric (1)	018	018
Translator Control Number	Control number assigned by the translator to each 837 claim submitted	Alpha/Numeric (15)	019	033
Translator Control Sequence Number	Uniquely identifies a claim/transaction.	Alpha/Numeric (4)	034	037
X12 Version	'4010'	Alpha/Numeric (4)	038	041
Batch Id	Batch filename	Alpha/Numeric (8)	042	049
Filler	Blank	Alpha/Numeric (4)	050	053
Provider Id	Provider Id submitted on the 837 claim	Alpha/Numeric (9)	054	062
Recipient Id	Recipient Id submitted on the 837 claim	Numeric (12)	063	074
Check Digit	Recipient's check digit submitted on the 837 claim	Numeric (1)	075	075
Patient Control Number	Patient Control Number submitted on the 837 claim	Alpha/Numeric (20)	076	095
Billed Amount Sign	"+", "-", or " "	Alpha/Numeric (1)	096	096
Billed Amount	Billed amount submitted on the 837 claim	Alpha/Numeric (12)	097	108
From Date of Service	From DOS submitted on the 837 claim	Numeric (8)	109	116
Return Code	'R' for rejected.	Alpha (1)	117	117
Error Count	01-50	Numeric (2)	118	119
Detail Number	0 specifies an error occurred at the header	Numeric (4)	*	*

Field Name	Field Value	Format (length)	Start Position	Stop Position
	> 0 specifies the detail number where the error code occurred			
Error Code	Error codes generated from processing the 837 claim	Alpha/Numeric (4)	*	*
Error Message	Upper case text description of error code	Alpha/Numeric (40)	*	*

***** These fields can occur 1 to 50 times depending on the error count. The detail number will begin at position 120, with a maximum record length of 2,519 bytes, if all 50 error codes are populated.

3. Tandem Error Codes and Messages

The following table shows each Tandem error code and the related error message.

Error Code	Error Message
0010	HEADER DATE OF SERVICE INVALID
0011	HEADER FDOS CANNOT BE A FUTURE DATE
0020	ADMISSION DATE INVALID
0021	ADMIT DATE CANNOT BE IN THE FUTURE
0022	ADMIT DATE CANNOT BE > BILLED FDOS
0030	HEADER TO DATE OF SERVICE INVALID
0031	HEADER TDOS CANNOT BE A FUTURE DATE
0032	HEADER TDOS CANNOT BE PRIOR TO THE FDOS
0051	SURGERY DT 1 NOT BETWEEN ADMIT AND TDOS
0052	SURGERY DT 2 NOT BETWEEN ADMIT AND TDOS
0053	SURGERY DT 3 NOT BETWEEN ADMIT AND TDOS
0054	SURGERY DT 4 NOT BETWEEN ADMIT AND TDOS
0055	SURGERY DT 5 NOT BETWEEN ADMIT AND TDOS
0060	DTL BILLED AMT =/< DTL NONCOVERED CHARGE
0061	NON COVERED CHARGE AMOUNT IS NOT NUMERIC
0062	NON COVERED CHARGE AMOUNT IS NEGATIVE
0063	NON COVERED CHRG EXCEEDS MAX MMIS SIZE
0064	NON COVERED CHRG EXCEEDS MMIS SIZE-NEG
0070	NUMBER DAYS/ BILLING PERIOD DISAGREE
0080	HEADER TDOS BEYOND 365-DAY FILING LIMIT
0081	HEADER TDOS BEYOND 120-DAY FILING LIMIT

Error Code	Error Message
0082	HEADER TDOS BEYOND PHP FILING LIMIT
0083	TPL PAID DT INVALID/BEYOND 365-DAY FILE
0100	PROCEDURE LIMITED TO REVENUE CODE 450
0130	NEONATAL REV CODE/DIAG CODE MISMATCH
0140	MODIFIER IS REQUIRED FOR BILLED PCODE
0141	MODIFIER REQUIRED TRANSPORT RELATED SVC
0150	TRANS SVC MUST BE MEDICALLY NECESSARY
0170	RECIPIENT AID CATEGORY IS NOT ELIGIBLE
0180	HOME HLTH/THERAPY SVC CANT BILL TOGETHER
0190	HIV COUNSEL CD BILLED WOUT HIV PLAN CD
0200	FPLAN-Z5190/99212 MUST ACCOM-Z5195/59430
0210	PHYSICAL THERAPY CANT BILL W/OTHER SVC
0220	DAYS COVERED INVALID
0230	ORGAN TRANSPLANTS REQUIRE PRIOR APPROVAL
0250	UNBORN RECIPIENT ELIGIBLE ONLY INFANT SV
0260	EPSDT RFRD THERAPY SVC ONLY POS 11 OR 99
0271	MODIFIER 1 VALID ONLY ON CROSSOVER CLAIM
0272	MODIFIER 2 VALID ONLY ON CROSSOVER CLAIM
0273	MODIFIER 3 VALID ONLY ON CROSSOVER CLAIM
0274	MODIFIER 4 VALID ONLY ON CROSSOVER CLAIM
0280	HDR PAID AMT CANT BE > SPECIFIED $$ AMT
0290	TYPE OF BILL INVALID
0300	UNITS ARE NOT NUMERIC
0301	CLAIM TYPE NOT IP, IX, LT, LX-UNITS NEG
0302	UNITS NUMERIC BUT MMIS SIZE EXCEEDED
0303	UNITS NUMERIC BUT NEG-MMIS SIZE EXCEEDED

Error Code	Error Message
0304	UNITS NOT EQUAL TO 1
0305	FRACTIONAL UNITS ARE NOT ALLOWED
0310	DETAIL RATE SUBMITTED IS INVALID
0320	MODIFIER 1 NOT EFFECTIVE FOR DOS
0321	MODIFIER 2 NOT EFFECTIVE FOR DOS
0322	MODIFIER 3 NOT EFFECTIVE FOR DOS
0323	MODIFIER 4 NOT EFFECTIVE FOR DOS
0330	INVALID REVENUE CODE FOR RECIPIENT > 1
0331	INVALID REV CODE FOR RECIPIENT < OR = 1
0340	CATARACT SVC REQUIRES PROPER MODIFIER
0360	SUBM RATE/UNITS/DTL CHRG NOT IN BALANCE
0370	NURSERY DAYS MUST NOT > 10 UNDER MOM NUM
0371	NURSERY DAYS/REVENUE CODES INVALID
0380	PRICING FILE INDICATES 0 - CONTACT EDS
0390	SVC NOT COVERED FOR INDICATED DIAGNOSIS
0400	QMB/EPSDT SVC LIMIT-QMB/EPSDT RLTD CLAIM
0401	SNF CAN ONLY BILL FOR QMB RECIPIENT
0410	MAXIMUM OF 23 LINES ALLOWED PER UB CLAIM
0420	RFRD CLAIM RESTRICTED TO RECIPIENT > 21
0430	BILLED AMOUNT MUST BE GREATER THAN ZERO
0431	BILLED AMOUNT MUST BE NUMERIC
0432	BILL AMT EXCEED MAX SIZE ALLOWED BY MMIS
0433	BILL AMT EXCEED MAX SIZE ALLOWED/IS NEG
0440	MEDICARE PAID AMT IS MISSING OR INVALID
0450	MEDICARE ALLOW AMT IS MISSING OR INVALID
0451	MEDICARE ALLOW AMT MUST BE > ZERO

Error Code	Error Message
0460	MEDICARE TOTAL BILL AMT MISSING/INVALID
0470	CO-INSURANCE AMOUNT IS INVALID
0471	CO-INSURANCE AMOUNT DOES NOT BALANCE
0480	REFERRING PHYSICIAN REQ ON EPSDT RFRL
0481	REFERRING PHYSICIAN NOT ON FILE
0482	REFERRING PHYSICIAN MUST=EPSDT SCRN PROV
0500	EPSDT SCREEN LIMITED-EPSDT SCREEN PROV
0510	PATIENT STATUS INVALID
0520	MCARE HDR ALLOW AMT NOT=SUM OF DTL AMT
0530	NET BILL AMT NOT =SUM DTL CHRG - TPL AMT
0540	SUM DTL NONCOV CHRG NOT=HDR NONCOV CHRG
0550	BILL AMT NOT = TO SUM OF DTL CHRG AMT
0560	MCARE HDR PDAMT NOT=SUM DTL MCARE PDAMT
0580	SVC MATERN WAVR REC-BILL WGLOBAL SVC FEE
0590	MW CLAIM MUST BE BILLED BY CONTRACT PROV
0600	MW PROV CAN ONLY BILL MW CARE CLAIMS
0610	INJECT/NONINJECT PROC CANT BILL TGTHR EP
0620	INPAT FQHC SVC CANT BILL WOTHER FQHC SVC
0630	REC - NO CNTY CD ON ELIGIBILITY FILE
0650	PROCEDURE CODE BILLED - INVALID FOR PROV
0660	ADMIT TYPE IS INVALID AS BILLED
0670	SVC FOR MATERN WVR REC REQUIRES PA
0680	HOSPICE COINSURANCE AMOUNT EXCEEDS $100
0681	HOSPICE CLAIM REQUIRES COINSURANCE AMT
0690	DENTAL SEALANT NOT PAYABLE FOR RECIPIENT
0691	DENTAL SEALANT NOT PAYABLE-TOOTH # SPECI

Error Code	Error Message
0710	INVALID POS FOR FQHC PROVIDER
0720	NO LEVEL 1 RECORD ON FILE FOR PROVIDER
0721	PCODE NOT ON LVL 1 FOR THE PROV AND DOS
0722	PCODE NO LONGER COVERED FOR PROVIDER
0730	FAMILY PLANNING SVC NOT COV FOR RECIPIEN
0731	FAM PLAN SVC (SURG CD 1) NOT COV FOR REC
0732	FAM PLAN SVC (SURG CD 2) NOT COV FOR REC
0733	FAM PLAN SVC (SURG CD 3) NOT COV FOR REC
0734	FAM PLAN SVC (SURG CD 4) NOT COV FOR REC
0735	FAM PLAN SVC (SURG CD 5) NOT COV FOR REC
0740	ONLY EPSDT PROV MUST BILL EPSDT REFERRAL
0760	DIAGNOSIS CODE BILLED - NOT COV FOR MHSP
0770	PROCEDURE CODE INVALID FOR PROV NUMBER
0780	CRITICAL CARE PROC CANT SPAN > TWO DAYS
0790	PCODE NOT VALID-RENAL DIALYSIS FACILITY
0810	PCODE CANT BE BILLED W/TYPE OF BILL 141
0820	DATES EXCEED SOBRA/QMB ELIGIBILITY
0840	SVC NOT COVERED-SOBRA ELIGIBLE RECIPIENT
0850	MATERN CARE PROV RESTRICTED-MATERN SVC
0860	REC INELIGIBLE FOR TARGET CASE MGMT
0870	DIFFERENT TCM PCODE-BILL SEPARATE CLAIMS
0880	CLIA NUMBER NOT ON FILE
0881	CLIA NUMBER INVALID FOR DATE OF SERVICE
0882	PROV CERTIFIED-CLIA PPMP/WVR PCODE ONLY
0883	PROV CERTIFIED-CLIA WVR PCODES ONLY
0890	MEDICARE PAID AMOUNT EQUAL 100%

Error Code	Error Message
0900	GLOBAL DELIVERY PCODE CANT BE SPAN DATED
0910	MEDICARE PAID DATE INVALID
0911	MEDICARE PAID DATE CANNOT BE FUTURE DATE
0920	TPL ADJUDICATION DATE INVALID
0921	TPL ADJUDICATION DT CANNOT BE FUTURE DT
0930	DTL COV > 1 PLAN W/IN MANAGED CARE PROG
0931	NOT ALL DTL COV BY SAME MANAGE CARE PROV
0932	REC PARTLY COV-MANAGED CARE PLAN, SPLIT
0934	SVC PARTLY COV BY MANAGED CARE PLAN, SPL
0940	COINSURANCE DAYS ARE NOT NUMERIC
0941	COINSURANCE DAYS ARE MISSING OR INVALID
0950	LIFETIME RESERVE DAYS BILLED NOT NUMERIC
0951	LIFETIME RSV DAY BILLED INVALID/EXCD MAX
0960	COINSURANCE/LIFETIME RSV DAYS INVALID
0980	SERVICE NOT COVERED BY MEDICAID
0981	REVENUE CODE NOT COVERED BY MEDICAID
0990	MEDICARE DEDUCTIBLE AMOUNT IS INVALID
1000	DETAIL FROM DATE OF SERVICE INVALID
1001	DETAIL FROM DOS CANNOT BE A FUTURE DATE
1010	DETAIL TO DATE OF SERVICE INVALID
1011	DETAIL TO DOS CANNOT BE A FUTURE DATE
1012	DETAIL TO DOS CANT BE PRIOR TO FROM DOS
1020	DETAIL DOS > THE 365-DAY FILING LIMIT
1021	DETAIL DOS > THE 120-DAY FILING LIMIT
1022	DETAIL DOS > THE 180-DAY FILING LIMIT
1023	PREV RA DT INVALID OR >365 DAY FILE LIMI

Error Code	Error Message
1030	THERAPY CD-PAY ONLY W/THERAPEUTIC TREATM
1040	PCODE 99281-99285, 99291-BILL ONCE ON CL
1050	SVC INCLUDED IN REV CD 450 FACILITY FEE
1070	PATIENT 1ST CLAIM REQ PMP PROV ON CLAIM
1080	REFERRING PROV REQUIRED FOR TCM DENTAL
1081	TCM REFERRING PROVIDER NOT ON FILE
1082	TCM REFERRING PROVIDER NOT ACTIVE
1083	TCM REFERRING PROV MUST BE A DENTAL PROV
1090	OBSERVATION CD MUST BILL W/FACILITY FEE
1100	INVALID DEDUCTIBLE AMT-SKILLED NURS FACI
1110	INPAT/OUTPAT NONCOV REV CD-EPSDT RFRL CL
1130	PROC NOT COV-AMBULATORY SURGICAL CENTER
1140	SERVICE NON-PAYABLE-RECIPIENT < 6 MONTHS
1230	ORAL CAVITY DESIGNATION CODE INVALID
1231	ORAL CAVITY DESIGNATION CODE INVALID
1232	ORAL CAVITY DESIGNATION CODE INVALID
1233	ORAL CAVITY DESIGNATION CODE INVALID
1234	ORAL CAVITY DESIGNATION CODE INVALID
1235	ORAL CAVITY DESIGNATION CODE INVALID
1236	ORAL CAVITY DESIGNATION CODE INVALID
1237	ORAL CAVITY DESIGNATION CODE INVALID
1238	ORAL CAVITY DESIGNATION CODE INVALID
1239	ORAL CAVITY DESIGNATION CODE INVALID
1240	TOOTH NUMBER LIMITED TO 1 PER DETAIL
1260	TOOTH SURFACE REQUIRED FOR PROCEDURE
1261	TOOTH SURFACE IS INVALID

Error Code	Error Message
1263	DUPLICATE TOOTH SURFACE INDICATED
1270	TOOTH NUMBER IS INVALID FOR PULP THERAPY
1280	TOOTH NUMBER IS REQUIRED FOR PROCEDURE
1281	TOOTH NUMBER IS INVALID
1290	PCODE NOT COV-PRIME TEETH/3RD MOLAR/SUPE
1300	INVALID CLAIM TYPE -PLAN FIRST PROGRAM
1310	SVC ONLY COV UNDER PLAN FIRST PROGRAM
1320	BIRTH CNTRL-MUST RCV FROM PLAN 1ST PROV
1330	PLAN 1ST REC MUST BE SEEN BY PLAN 1ST PR
1340	PLAN 1ST REC -ONLY ELIGIBLE PLAN 1ST SVC
1350	PCODE RESTRICTED TO TECH ASST WVR REC
1360	PLACE OF SERVICE CODE IS INVALID
1440	PLACE OF SERVICE INVALID FOR PROV TYPE
1451	FIRST MODIFIER IS INVALID
1452	SECOND MODIFIER IS INVALID
1453	THIRD MODIFIER IS INVALID
1454	FOURTH MODIFIER IS INVALID
1460	PCODE INAPPROPRIATE FOR THIS PROV TYPE
1471	FIRST MODIFIER INVALID FOR PCODE BILLED
1472	SECOND MODIFIER INVALID FOR PCODE BILLED
1473	THIRD MODIFIER INVALID FOR PCODE BILLED
1474	FOURTH MODIFIER INVALID FOR PCODE BILLED
1480	PLACE OF SERVICE CODE INVALID FOR PCODE
1490	PCODE INAPPROPRIATE FOR RECIPIENT AGE
1491	REV CODE INAPPROPRIATE FOR RECIPIENT AGE
1499	NDC INAPPROPRIATE FOR RECIPIENT AGE

Error Code	Error Message
1500	PCODE INAPPROPRIATE FOR RECIPIENT SEX
1501	REV CODE INAPPROPRIATE FOR RECIPIENT SEX
1509	NDC INAPPROPRIATE FOR RECIPIENT SEX
1510	PROCEDURE CODE NOT FOUND FOR DOS
1511	REVENUE CODE NOT FOUND FOR DOS
1515	SVC DT SPANS PCODE EFFECTIVE DT SEGMENTS
1516	SVC DT SPANS REV CD EFFECTIVE DT SEGMENT
1519	NDC IS INVALID FOR DOS
1520	SERVICE CODE MISSING OR INVALID
1521	REVENUE CODE MISSING OR INVALID
1528	INVALID QUALIFIER LIST CODE
1529	NDC IS NOT ON FILE
1530	DIAG INAPPROPRIATE FOR PROC BILLED
1531	1ST DIAG INAPPROPRIATE FOR PROC BILLED
1532	2ND DIAG INAPPROPRIATE FOR PROC BILLED
1533	3RD DIAG INAPPROPRIATE FOR PROC BILLED
1534	4TH DIAG INAPPROPRIATE FOR PROC BILLED
1535	5TH DIAG INAPPROPRIATE FOR PROC BILLED
1536	6TH DIAG INAPPROPRIATE FOR PROC BILLED
1537	7TH DIAG INAPPROPRIATE FOR PROC BILLED
1538	8TH DIAG INAPPROPRIATE FOR PROC BILLED
1540	PCODE INAPPROPRIATE FOR PROV SPECIALTY
1550	PROCEDURE CODE INVALID FOR CLAIM TYPE
1551	REVENUE CODE INVALID FOR CLAIM TYPE
1560	PROCEDURE CODE ON REVIEW FOR PROVIDER
1610	PROCEDURE INVALID FOR SERVICE PERFORMED

Error Code	Error Message
1611	REVENUE CODE INVALID OR NOT ON FILE
1620	UNITS BILLED EXCEED MAX ALLOWED PER DAY
1640	ACCOMMODATION UNITS DO NOT = COV DAYS
1641	NO ACCOMMODATION REVENUE CODES BILLED
1740	DIAGNOSIS REQUIRES ACCIDENT INDICATOR
1750	OPERATION OR DELIVERY REQ SURGICAL PCODE
1830	DOS BEFORE RECIPIENT DATE OF BIRTH
1840	SVC NOT COV FOR RECIPIENT > OR = 22
1850	PROCEDURE NOT COVERED AT POS FOR PROV
1890	DIAG INAPPROPRIATE FOR PROV SPECIALTY
1900	PRIMARY DIAGNOSIS IS NOT ON FILE
1910	SECONDARY DIAGNOSIS IS INVALID
1923	THIRD DIAGNOSIS IS INVALID
1924	FOURTH DIAGNOSIS IS INVALID
1925	FIFTH DIAGNOSIS IS INVALID
1926	SIXTH DIAGNOSIS IS INVALID
1927	SEVENTH DIAGNOSIS IS INVALID
1928	EIGHTH DIAGNOSIS IS INVALID
1940	PRIMARY DIAG NOT APPROPRIATE FOR REC AGE
1952	HDR DIAG 2 NOT APPROPRIATE FOR REC AGE
1953	HDR DIAG 3 NOT APPROPRIATE FOR REC AGE
1954	HDR DIAG 4 NOT APPROPRIATE FOR REC AGE
1955	HDR DIAG 5 NOT APPROPRIATE FOR REC AGE
1956	HDR DIAG 6 NOT APPROPRIATE FOR REC AGE
1957	HDR DIAG 7 NOT APPROPRIATE FOR REC AGE
1958	HDR DIAG 8 NOT APPROPRIATE FOR REC AGE

Error Code	Error Message
1960	PRIMARY DIAG NOT APPROPRIATE FOR REC SEX
1972	2ND DIAG NOT APPROPRIATE FOR REC SEX
1973	HDR DIAG 3 NOT APPROPRIATE FOR REC SEX
1974	HDR DIAG 4 NOT APPROPRIATE FOR REC SEX
1975	HDR DIAG 5 NOT APPROPRIATE FOR REC SEX
1976	HDR DIAG 6 NOT APPROPRIATE FOR REC SEX
1977	HDR DIAG 7 NOT APPROPRIATE FOR REC SEX
1978	HDR DIAG 8 NOT APPROPRIATE FOR REC SEX
2051	DETAIL DIAGNOSIS 1 INVALID
2052	DETAIL DIAGNOSIS 2 INVALID
2053	DETAIL DIAGNOSIS 3 INVALID
2054	DETAIL DIAGNOSIS 4 INVALID
2071	DTL DIAG 1 NOT APPROPRIATE FOR REC AGE
2072	DTL DIAG 2 NOT APPROPRIATE FOR REC AGE
2073	DTL DIAG 3 NOT APPROPRIATE FOR REC AGE
2074	DTL DIAG 4 NOT APPROPRIATE FOR REC AGE
2180	PERFORM PROV IDENT FOR PURGE-CALL EDS
2190	BILL PROV IDENT FOR PURGE - CALL EDS
2200	PROV NOT AUTH TO BILL ELECTRONICALLY
2210	PROVIDER DECEASED ON DOS BEING BILLED
2220	PROV ADDR ON FILE NOT CURR-MAIL RETURNED
2230	PROVIDER SUSPENDED FROM MCAID PROGRAM
2240	PROVIDER HAS BEEN CANCELED
2250	PROVIDER RATE NOT FOUND FOR DOS BILLED
2260	CLAIM TYPE NOT VALID FOR THIS PROVIDER
2270	PROVIDER NOT ELIGIBLE FOR MEDICAID

Error Code	Error Message
2280	PROVIDER INELIGIBLE ON DOS BEING BILLED
2290	PROVIDER NUMBER IS INVALID
2291	PROVIDER NUMBER IS NOT ON FILE
2292	PROVIDER NAME AND NUMBER DISAGREE
2293	PROV SPECIALTY NOT FOUND FOR DOS SUBMIT
2300	ATTENDING PHYSICIAN LICENSE NUM MISSING
2350	BILLING PROVIDER MUST BE GROUP PROV NUM
2360	PERFORMING PROV CANNOT BE GROUP PROV NUM
2370	PROVIDER NUMBER IS NOT ON FILE
2371	PROV ACT REAS CD SEG 40,42,49,50 CANCEL
2372	PROV ACTION REASON CD SEGMENT 41-DECEASE
2373	PERFORM PROV CANNOT BE SPACES OR ZEROS
2380	PERFORM PROV NOT ASSOCIATED WITH GROUP
2390	PROV ELIGIBLE FOR ONLY QMB RECIPIENTS
2480	ELIGIBLE MCARE ONLY-NO MCAID/QMB BENEFIT
2500	RECIPIENT NUMBER NOT ON FILE
2501	RECIPIENT NUMBER MISSING OR ZEROS
2502	RECIPIENT ON XREF BUT NOT ON BASE
2510	REC HAS AN UNUSABLE RECORD - CONTACT EDS
2540	RECIPIENT TOTALLY INELIGIBLE FOR HDR DOS
2550	REC PARTIALLY INELIGIBLE FOR HDR DOS
2560	RECIPIENT NUMBER NOT ON FILE
2580	REC LOCKED INTO SPEC PHAR/NO PHAR SELECT
2581	REC LOCKED INTO DIFF PROV/NO PHAR SELECT
2582	REC LOCKED OUT OF SPECIFIC DRUGS
2583	REC LOCKED OUT OF CONTROLLED SUBSTANCES

Error Code	Error Message
2590	RECIPIENT ID INVALID FOR RECIPIENT FNAME
2591	RECIPIENT NAME IS REQUIRED
2620	RECIPIENT TOTALLY INELIGIBLE FOR DTL DOS
2630	REC PARTIALLY INELIGIBLE FOR DTL DOS
2640	REC INELIGIBLE-GERIATRIC/INPAT PYSCH SVC
2700	REC NOT ON LTC ELIGIBILITY FILE FOR DOS
2720	PROV DOESNT MATCH PROV ON LTC FILE -REC
2760	RECIPIENT INELIGIBLE FOR WAIVERED SVC
2761	REC INELIGIBLE FOR WVR SVC-THIS PROV
2762	PROVIDER NOT ELIGIBLE FOR WAIVERED SVC
2800	REC HAS OTHER INSURANCE-FILE 3RD PARTY
2820	RECIPIENT IS MEDICARE SUSPECT
2831	TYPE OF SERVICE NOT VALID FOR MODIFIER 1
2832	TYPE OF SERVICE NOT VALID FOR MODIFIER 2
2833	TYPE OF SERVICE NOT VALID FOR MODIFIER 3
2834	TYPE OF SERVICE NOT VALID FOR MODIFIER 4
2920	PCODE/TOS INVALID FOR RADIOLOGY FACILITY
2950	PROD PROV CANT BILL CLAIM FOR TEST REC
2951	TEST PROV CANT BILL CLAIM FOR PROD REC
3000	VACC PCODE ONLY PAYABLE UNDER VFC PGM
3040	SURGERY PROVIDER NUMBER IS INVALID
3100	DETAIL CHARGE AMOUNT IS ZERO
3101	DETAIL CHARGE AMOUNT IS NOT NUMERIC
3102	DETAIL CHARGE AMOUNT IS NEGATIVE
3103	DTL CHRG AMT EXCEEDS MAX SIZE ALLOWED
3104	DTL CHRG AMT EXCEEDS MAX SIZE AND IS NEG

Error Code	Error Message
3110	NON COVERED CHARGE AMOUNT IS INVALID
3130	ADMITTING DIAGNOSIS IS NOT ON FILE
3140	FDOS AND TDOS MUST BE W/IN SAME MONTH
3150	FDOS/TDOS MUST NOT SPAN CALENDAR YEAR
3160	DATE RANGE CANNOT EXCEED 90 DAYS
3190	COVERED DAYS > CERTIFIED DAYS
3200	PSRO APPROVED FROM DATE IS INVALID
3201	PSRO APPROVED TO DT CANT BE A FUTURE DT
3202	PSRO APPROVED TO DATE IS INVALID
3203	PSRO APPROV FDATE CANT>PSRO APPROV TDATE
3221	SURG DT 1 REQ IF SURG PCODE 1 PRESENT
3222	SURG DT 2 REQ IF SURG PCODE 2 PRESENT
3223	SURG DT 3 REQ IF SURG PCODE 3 PRESENT
3224	SURG DT 4 REQ IF SURG PCODE 4 PRESENT
3225	SURG DT 5 REQ IF SURG PCODE 5 PRESENT
3229	OPER PHYS REQ IF SURG PCODE PRESENT
3230	INVALID CLAIM SUBMISSION REASON CODE
3231	ORIG ICN IS NOT VALID ON AN ORIG CLAIM
3232	MUST SUPPLY ORIG ICN ON AN ADJST REQUEST
3570	SUBMITTED CHARGE > SIX TIMES THE ALLOWED
3820	ORIGINAL ICN CANNOT BE ADJUSTED
3821	ORIG CLAIM STATUS INVALID FOR ADJUSTMENT
3822	ADJST OF ORIG CLAIM ALREADY IN PROGRESS
3823	ORIG PROV AND/OR RECIPIENT NOT MATCHED
3829	INVALID MMIS ADJUSTMENT
3890	PRIOR AUTHORIZATION NUMBER NOT ON FILE

Error Code	Error Message
3891	PRIOR AUTHORIZATION NUMBER NOT NUMERIC
3892	PRIOR AUTH HAS NOT BEEN APPROVED
3900	CLAIM AND PRIOR AUTH PROV DO NOT MATCH
3910	PRIOR AUTH REQ DT OVERLAP DOS ON CLAIM
3920	PRIOR AUTHORIZATION UNITS ARE EXHAUSTED
3930	RECIPIENT ID DOES NOT MATCH PA REC ID
3970	PA NUMBER DOES NOT MATCH PROC BILLED
3971	PA NUMBER DOES NOT MATCH DOS BILLED
3980	ALLOWED CHRG EXCEED AUTH DOLLARS-PA FILE
3990	PRIOR AUTHORIZATION REQUIRED
3991	PA REQ FOR INPATIENT PYSCH RELATED SVC
3992	PA REQ FOR CERTAIN TRANSPORTATION SVC
3993	PA REQUIRED FOR POS BILLED
3994	PA REQ -PERSONAL CARE/PRIVATE DUTY NURS
3995	PRIV DUTY NURS SVC REQ PA/EPSDT RFRL
3996	PA REQ FOR INPT PLAN 1ST TUBAL LIGATION
3999	PRIOR AUTHORIZATION REQUIRED FOR NDC
4910	DUP PHARMACY CLAIM FOR DOS AND GCN
4930	DUPLICATE RX CD, REFILL NUMBER, AND NDC
9000	PRESCRIPTION NUMBER MISSING OR INVALID
9010	DRUG QUANTITY CANNOT BE ZERO
9011	DRUG QUANTITY MUST BE NUMERIC
9031	DAYS SUPPLY EQUAL TO ZERO
9032	DAYS SUPPLY MUST BE NUMERIC
9040	DATE PRESCRIBED IS INVALID OR MISSING
9070	PRESCRIBING PROV LICENSE NUM NOT ON FILE

Error Code	Error Message
9071	PRESCRIBING PROV LICENSE NUMBER INACTIVE
9080	DATE DISPENSED PRIOR TO DATE PRESCRIBED
9110	REFILL NUM EXCEEDS REFILLS ALLOWED-NDC
9111	REFILL INDICATOR NOT NUMERIC
9300	MEDICAL NECESSITY(DAW) INDICATOR INVALID
9301	MED NECESSITY(DAW) INDICATOR NOT NUMERIC
9310	MISSING/INVALID SVC PROV ID QUALIFIER
9320	MISSING/INVALID INSURANCE SEGMENT
9330	MISSING/INVALID CLAIM SEGMENT
9340	PRODUCT/SERVICE NOT COVERED
9350	MISSING/INVALID PRODUCT/SVC ID QUALIFIER
9360	MISSING/INVALID PRESCRIBER SEGMENT
9370	MISSING/INVALID PRESCRIBER ID QUALIFIER
9380	MISSING/INVALID PRICING SEGMENT
9390	MISSING/INVALID OTHER PAYER AMT PAID QUA
9410	COPAY EXEMPTION INDICATOR NOT VALID
9500	DUR CONFLICT CODE IS INVALID
9501	DUR INTERVENTION CODE INVALID
9502	DUR OUTCOME CODE INVALID
9510	ALERT TO OVERRIDE CANNOT BE FOUND
9511	CLAIM TO CANCEL CANNOT BE FOUND
9520	PRV ALERT CLM CANT BE OVR-ALERT NOT FND
9521	PREV ALERT CLAIM CANT BE OVERRID-DUR FIE
9522	PREV ALERT CLAIM CANT BE OVERRID-DUR FIE
9523	PREV ALERT CLAIM CANT BE OVERRID-PA REQ
9990	HOST PROCESSING ERROR

Error Code	Error Message
9991	HOST PROCESSING ERROR
9992	HOST PROCESSING ERROR
9993	HOST PROCESSING ERROR
9994	HOST PROCESSING ERROR
9995	HOST PROCESSING ERROR
9996	HOST PROCESSING ERROR
9997	HOST PROCESSING ERROR
9998	HOST PROCESSING ERROR
9999	HOST PROCESSING ERROR
A030	MAX QUANTITY EXCEEDED FOR 30-DAY PERIOD
Z041	RELATED CAUSE CODE 1 INVALID
Z042	RELATED CAUSE CODE 2 INVALID
Z043	RELATED CAUSE CODE 3 INVALID
Z110	DETAIL DOS NOT WITHIN THE HEADER DOS
Z111	CALCULATED TDOS NOT W/IN HEADER DOS
Z140	ADMISSION HOUR IS INVALID
Z141	ADMISSION MINUTE INVALID
Z160	DISCHARGE HOUR IS INVALID
Z161	DISCHARGE MINUTE INVALID
Z170	NON-COVERED DAYS ARE INVALID
Z181	OCCURRENCE CODE 1 IS INVALID
Z182	OCCURRENCE CODE 2 IS INVALID
Z183	OCCURRENCE CODE 3 IS INVALID
Z184	OCCURRENCE CODE 4 IS INVALID
Z185	OCCURRENCE CODE 5 IS INVALID
Z191	OCCURRENCE DATE 1 IS INVALID

Error Code	Error Message
Z192	OCCURRENCE DATE 2 IS INVALID
Z193	OCCURRENCE DATE 3 IS INVALID
Z194	OCCURRENCE DATE 4 IS INVALID
Z195	OCCURRENCE DATE 5 IS INVALID
Z201	OCCURRENCE DT 1 NOT BETWEEN FDOS/TDOS
Z202	OCCURRENCE DT 2 NOT BETWEEN FDOS/TDOS
Z203	OCCURRENCE DT 3 NOT BETWEEN FDOS/TDOS
Z204	OCCURRENCE DT 4 NOT BETWEEN FDOS/TDOS
Z205	OCCURRENCE DT 5 NOT BETWEEN FDOS/TDOS
Z211	CONDITION CODE 1 IS INVALID
Z212	CONDITION CODE 2 IS INVALID
Z213	CONDITION CODE 3 IS INVALID
Z214	CONDITION CODE 4 IS INVALID
Z215	CONDITION CODE 5 IS INVALID
Z221	TPL AMOUNT MUST BE NUMERIC
Z225	THIRD PARTY AMT EXCEEDS TOTAL BILLED
Z230	SURGERY COUNT MISSING OR INVALID
Z231	OCCURRENCE COUNT MISSING OR INVALID
Z232	CONDITION COUNT MISSING OR INVALID
Z233	DIAGNOSIS COUNT MISSING OR INVALID
Z310	SOCIAL SECURITY NUMBER NOT FOUND
Z311	NO RECIPIENT FOUND THAT MATCHES REQUEST
Z312	MULTIPLE REC FOUND RESUBMIT W/ADDITIONAL
Z313	LAST NAME DOES NOT MATCH SSN
Z314	FIRST NAME DOES NOT MATCH SSN
Z315	MIDDLE INITIAL DOES NOT MATCH SSN

Error Code	Error Message
Z316	DATE OF BIRTH DOES NOT MATCH SSN
Z800	CLAIM HAS ALREADY BEEN REVERSED
Z801	RX NUMBER NOT FOUND ON CLAIM
Z803	RX NUMBER IS NOT NUMERIC
Z804	NON-MATCHED NDC NUMBER
Z810	INVALID ICN
Z811	ICN NOT FOUND ON CLAIM FILE
Z812	INVALID ICN FOR CLAIM TYPE
Z813	CLAIM HAS ALREADY BEEN REVERSED
Z820	RECIPIENT ID/CLAIM RECORD MISMATCH
Z830	PROVIDER ID/CLAIM RECORD MISMATCH
Z840	CAN ONLY REVERSE CLM SAME DAY SUBMITTED
Z990	DETAIL COUNT MISSING OR INVALID

Appendix A: Abbreviations

The following table shows common abbreviations that have been used throughout the error messages and will help in interpreting the complete message.

Abbreviation	Definition
ADJ	Adjustment
AMT	Amount
AUTH	Authorization
CD	Code
CHRG	Charge
CNTY	County
COV	Covered
CURR	Current
DIAG	Diagnosis
DOS	Date of Service
DT	Date
DTL	Detail
FDATE	From Date
FDOS	From Date of Service
FNAME	First Name
FPLAN	Family Plan
HDR	Header
HLTH	Health
INPAT	Inpatient
LNAME	Last Name
LVL	Level
MATERN	Maternity
MAX	Maximum
MCAID	Medicaid

MCARE	Medicare
MGMT	Management
MIN	Minimum
MOD	Modifier
MW	Maternity Waiver
NEG	Negative
NONCOV	Non-Covered
NUM	Number
ORIG	Original
OUTPAT	Outpatient
PAT	Patient
PAY	Pay or Payable
PCODE	Procedure Code
PDAMT	Paid Amount
POS	Place of Service
PREV	Previous
PROC	Procedure/Procedures
PROV	Provider
RCVD	Received
REC	Recipient
REQ	Require/Requires/Required
REV	Revenue
RFRD	Referred
RFRL	Referral
RLTD	Related
RSV	Reserve
SCRN	Screen
SUBM	Submitted
SURG	Surgery
SVC	Service/Services
TDATE	To Date

TDOS	To Date of Service
TECH	Technology
TGTHR	Together
TOS	Type of Service
TRANS	Transportation
WOUT	Without
WVR	Waiver

Appendix B – TRANSACTION CODES

APDE	837 DENTAL
APHC	837 PROFESSIONAL (HCFA)
APIP	837 INSTITUTIONAL (INPATIENT HOSPITAL)
APLT	837 INSTITUTIONAL (LONG TERM CARE)
APOP	837 INSTITUTIONAL (OUTPATIENT HOSPITAL)
APLX	837 INSTITUTIONAL (LONG TERM CARE CROSSOVER)
APMX	837 PROFESSIONAL (HCFA CROSSOVER)
APIX	837 INSTITUTIONAL (INPATIENT HOSPITAL CROSSOVER)
APOX	837 INSTITUTIONAL (OUTPATIENT HOSPITAL CROSSOVER)
ALCR	837 CLAIM ADJUSTMENT